Medical Coverage

Enrollment and Change Form

☐ Board of Education School Employee
☐ County Government Employee

Check appropriate options:

☐ New Hire Enrollment, provide Hire Date: _____

☐ Open Enrollment:
- ☐ Terminate Dependent or Add Dependent during open enrollment
- ☐ Change current medical coverage at op en enrollment from_____to:_____

☐ Qualifying Event: **Enrollment due to a qualifying event requires proof validating the event.**
Qualifying Event Date: _____
Qualifying Event Reason, please choose one
☐ Marriage ☐ Divorce ☐ Birth ☐ Loss of Coverage

Employee Name _____Male or Female
Employee SS#_____ Employee date of birth_____
Address: _____
City: _____ State: _____ Zip: _____
Work Location _____
Best contact number (phone and/or e-mail) _____
Is your spouse an employee of the Board of Education or County Government? Yes___ No ___ If so, name of your spouse_____

Enrollment Election

$500 Deductible Medical Plan

☐ I elect enrollment in the $500 Deductible Medical Plan.

$1250 Deductible Medical Plan with HSA

☐ I elect enrollment in the $1250 Deductible Medical Plan with HSA.

If you are enrolling in the $1250 deductible with HSA, you must set up your bank account as part of the open enrollment process. Please follow the below URL link for the online setup of your HSA account.

https://preenroll.healthcare.cigna.com/healthcare/preenroll/app/bank/welcome.do

Open Enrollment ID : **WilliamsonHSA**

Choose the annual amount you would like to have withheld from your salary and placed into your HSA account for reimbursement of eligible health care expenses. Your 2014 election may be $0 to $2,800 for individual coverage or $0 to $5,550 for family coverage. Annual Amount Elected: $_____

Annual amount elected will be divided by the number of pay periods remaining from January – December by the Benefits Department

☐ I Decline Medical Coverage

List all family members to be enrolled or terminated

First, M.I., & Last Name	SEX	Enrollment Election	Social Security #	Birth Date
Spouse	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -

Enrollment of a spouse: The spousal form must accompany this enrollment form.
Enrollment of a child: Copy of the childs birth certificate must accompany this enrollment form.

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee's Signature: _____ Date: _____